Definitions (Search by Question or Section Number)

Section 1—DATES OF OPERATION, OWNERSHIP AND ORGANIZATION TYPE

Question 1

Date Facility First Licensed in Maryland:

The date that Office of Health Care Quality (OHCQ) approved your facility to start doing business as a licensed provider in the state of Maryland as issued on your OHCQ original license.

Dates of Operation in Survey Year:

The entire period during the survey year that the facility admitted patients. A change in facility ownership does not affect the Beginning and Ending Dates of Operation.

Question 2

Ownership:

Any change in the ownership including legal name of the facility that occurred during the calendar year being surveyed.

Question 3

Type of Business Organization:

The type of legal entity of the business or organization that owns your facility. Do not report a management company unless they are the majority owner.

Question 4

Nursing Home Chain:

"Chain" facilities are facilities which are owned or leased by a multi-facility organization. The remaining facilities are individually owned and operated. Do not report the name of the

management company that manages the facility unless it is the same chain that owns or leases the facility.

Question 5

Parent Organization Sponsorship:

The Adult Day Care Center is owned /operated by an organization for which the Adult Day Care Center is not the primary business. This question identifies the type of parent organization that owns/operates the Adult Day Care Center.

Section 2—CERTIFICATION, ACCREDITATION AND LICENSING AND PARTICIPATION

Certification

Question 6

Medicaid Provider Number:

A Provider must apply for and receive certification from the Maryland Medical Assistance Program to receive payment from Maryland Medical Assistance (MEDICAID) programs. When a facility has been approved to receive payment from Medicaid, Maryland Medicaid issues a Medicaid Provider Number.

Question 7

National Provider Identifier (NPI) Number:

The Centers for Medicare and Medicaid Services (CMS) issued this number in lieu of legacy provider identifiers such as, Medicaid Provider Number, to be used by Providers for HIPPA standard transaction including claims and other transactions for payment.

“An NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). Intelligence-free means the number does not carry information about health care providers, such as the state where the provider practices, the provider type, or the provider’s specialization.

The NPI must be used in place of legacy provider identifiers, such as a Unique Provider Identification Number (UPIN), Online Survey Certification & Reporting (OSCAR), and National

Supplier Clearinghouse (NSC) in HIPAA standard transactions." Source: http://www.cms.hhs.gov/NationalProvIdentStand/

Question 8

Medicare Provider Number:

A Provider must apply for and receive certification from the Centers for Medicare and Medicaid Services (CMS) that entitles the facility to receive payment from Medicare programs. When a facility has been certified to receive payment from Medicare programs, CMS issues a Medicare Provider Number.

Accreditation

Question 9

CARF Certified:

Accreditation by The Commission on Accreditation of Rehabilitation Facilities (CARF), the private nonprofit organization formed in 1966, to establish standards of quality for rehabilitation services. For more information visit www.carf.org.

Question 10

JACHO Certified:

Accreditation by Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission began in 1966 for long term care organizations with beds licensed by the state either as nursing home beds or as beds under a hospital license, beds certified by Medicare and Medicaid and beds designated by the Department of Veteran's Affairs or a state authority. For more information visit www.jointcommission.org

Licensing and Participation

Question 11

DHMH Licenses:

The Adult Day Care Center may hold additional Department of Health and Mental Hygiene licenses for its day care slots from the Developmental Disabilities Administration and/or the Mental Hygiene Administration.

Question 12

Long Term Care Insurance:

Private Long Term Care Insurance is a non-governmental private insurance company policy that specifically covers a nursing home stay. Managed Care Contracts/HMOs provide an integrated system of financing and delivery through a contract between an insurer and provider (nursing home) to provide comprehensive long term care services to enrolled members for a predetermined rate.

Question 13

Certified Nursing Assistant (CNA):

A State-approved Nurse Aide Training and Competency Evaluation Program conducted at your facility. Certified Nurse Aide is an individual who has completed a State-approved training and competency evaluation program, or competency evaluation program approved by the State, or has been determined competent and who provides nursing or nursing-related services to residents. Do not include volunteers at the facility.

Section 3--BED INVENTORY, PHYSICAL CAPACITY AND UTILIZATION

Bed Inventory and Physical Capacity

Question 14

Numbers of Licensed Beds or Slots - Beginning Date Operation (BDO):

The number of beds /slots that the facility or center may operate at the Beginning Date of Operation for the Calendar Year is stated on the license from the Office of Health Care Quality. Beds operated in licensure categories other than those surveyed and facilities that are not licensed, such as independent living units, by the Department of Health and Mental Hygiene should be excluded.

Question 15

Numbers of Licensed Beds or Slots - Ending Date Operation (EDO):

The number of beds that the facility may operate at the Ending Date of Operation for the Calendar Year is stated on the license from the Office of Health Care Quality. Beds operated in licensure categories other than those surveyed and facilities, such as independent living units, that are not licensed by the Department of Health and Mental Hygiene should be excluded.

Breakdown of Facility BED Types:

The breakdown of your facility's licensed beds by bed type as described on your OHCQ license. The total of all beds must be the same as the number of license beds on the Ending Date of Operation in the survey year.

Question 16

Toilets:

The total number of toilets available for use at the facility. This includes all toilets accessible by the staff such as private toilets assigned to a room, toilets located between rooms, as well as, toilets in the hallways that may be detached from a patient’s room.

Question 17

Change in Licensed Bed or Slots Capacity:

Any official change approved by OHCQ in the number of beds or adult day care slots on the OHCQ issued license that took place during the calendar year. Beds or slots that have been temporarily delicensed through the Office of Health Care Quality should be included.

Changes in beds or slots, such as beds which have been temporarily closed for minor renovations, which did not increase or decrease licensed capacity are to be excluded. Slots temporarily not staffed, that did not increase or decrease the capacity of the center/program, should also be excluded.

Note: The dates the change took place must be within the beginning and ending dates of the survey year.

Question 18:

Restrictions on Number of Licensed beds:

Restrictions on the number of licensed beds operated by your facility during the calendar year. Bed restrictions refer to licensed bed capacity that is not operated or staffed, including voluntary admissions ceilings, and Office of Health Care Quality admission bans. Report only restrictions that have been approved by the Office of Health Care Quality.

Note: The beginning and ending effective dates of the change must be within the beginning and ending dates of the survey year.

Question 19:

Physical Capacity:

The facility's physical capacity refers to the total number of beds each room can accommodate by its total size regardless of the actual number of beds operating in that room.

Utilization

Question 20:

Number of Residents on the BDO:

The number of residents on the facility's register or census on the Beginning Date of Operation (BDO) of the Calendar Year.

NOTE 1: For the purpose of the Maryland Long Term Care Survey, "Beginning Date of Operation" means the date the facility first accepted residents into the facility in the Calendar Year.

NOTE 2: For the purpose of the Maryland Long Term Care Survey, we consider the number of residents on January 1 of the survey year to be the same number of residents at the facility at, Midnight on December 31 of the previous year.

NOTE 3: If your facility participated in last year's Long Term Care Survey, the number of Residents at the end of last year has been entered (pre populated) for you into this question.

NOTE 4: If your facility opened for the first time during the calendar year report "0" in this question. Then report all newly admitted residents under Admissions.

Total Number of Participants Enrolled—(Adult Day Care):

The total number of participants actually enrolled on the facility's register on the Beginning Date of Operation and on the Ending Date of Operation. The number of participants (enrollees) in the center on the Beginning Date of Operation and on the Ending Date of Operation, including those receiving care in an acute care hospital, or otherwise temporarily absent, provided that a slot was held for the participant.

Question 21

Number of Admissions:

The total number of residents admitted to the facility during the calendar year. The admissions reported should reflect the number of residents accepted for care during the calendar year. Exclude those residents readmitted to the facility following transfer to an acute care hospital, or other location, provided that a bed was held for the resident during the period of time that he or she was away from the facility (up to 14 days bed hold). Include transfers from one long term care bed licensure category to another, even though they occurred in the same facility. Residents who returned to the facility within 24 hours of discharge are not considered as discharged or re-admitted for the purposes of this survey.

NOTE 1: Any resident accepted at the facility on January 1 of a survey year is an ADMISSION and should be entered as such. Any resident accepted at the facility on December 31 of a survey year is also an ADMISSION and should be entered as such.

NOTE 2: A resident who returns to the facility before the bed hold expires is not considered an admission.

Question 22

Number of Discharges:

The total number of residents released from the facility during the survey year to home or other locations excluding death. Discharges include transfers from one long term care bed licensure category to another (e.g., those discharged from an assisted living bed and admitted to a comprehensive care bed).

Residents transferred to an acute care hospital or to another location who returned to the facility, or were expected to return to the facility, are not considered discharged provided that a bed was

held for 14 days or less for the resident during the period of time that he or she was away from the facility. Residents who returned to the facility within 24 hours of discharge are not considered discharges for the purposes of this survey.

Question 23:

Number of Deaths (Discharge Due to Death):

The total number of persons who died while residents of the facility. The number of deaths reported should include all persons who died while a resident of the facility. This includes deaths occurring to residents who temporarily transferred to an acute care hospital while a bed was being held at the facility.

Question 24

Number of Residents on the EDO:

The total number of residents on the facility's register or census on the Ending Date of Operation (EDO). The number of residents reported should include residents temporarily transferred to an acute care hospital or other location, provided a bed was held for the resident.

NOTE 1: For the purpose of the Long Term Care Survey, we consider the number of residents on December 31 to be the number of residents at the facility at 12:00 midnight.

NOTE 2: If the facility closed on the last day of operation and all residents have been transferred out of the facility then "0" should be reported in this question.

NOTE 4: Any resident released from the facility to an acute care hospital or other location is still considered a resident if their stay includes a bed hold which falls on the last day of operation or December 31 (if the facility is opened for the whole year).

NOTE: Number of Residents at the beginning (Residents BDO) date of the survey year, *Plus* any Residents admitted during the year (Admissions), *Minus* any Residents that have been Discharged or Died (Discharges and Deaths) during the survey year should equal the *Number of residents on the ending date of the survey year (Resident EDO).*

Question 25

Total Patient Days--(Comprehensive, Assisted Living and Chronic Days):

The total number of patient days of care provided at the facility during the calendar year. The number of patient days reported equals the sum of the daily patient census count during the calendar year. Include days that a bed was held for a resident temporarily away from the facility (i.e. bed holds of 14 days or less).

NOTE: For the purpose of the Long Term Care Survey, if your facility's Fiscal Year is the same as the Calendar Year, i.e., they are both 01/01/YYYY to 12/31/YYYY, then Total Patient Days must be the same as Total Routine Patient Days on the financial report question.

Total Number of Days Service Provided (Adult Day Care):

Days of Service for **Participants Present** is the total number of days of care provided to all participants who attended the center each quarter. This does not include the days the participants were scheduled to attend, but were absent.

Days of Service for **Participants Enrolled** is the total number of days all participants were scheduled to attend the center each quarter (i.e., the sum of the total number of days of attendance of each participant added to the total number of days of absence for each participant).

Question 26

Total Number of Days Open for the Year:

The cumulative number of days the center was open to participants by each quarter of the calendar year. The total number of days for the four quarters should not be greater than 365, except in a leap year which would be 366.

Question 27

Total Number of Days Open for the Week:

The number of days the center was open to receive participants during a week. If the center accepts participants on a Saturday, and or, Sunday, these days must be included in the count.

Question 28

Facility Licensed Level of Care:

The Office of Health Care Quality licenses assisted living facilities to provide a specific level of care during the calendar year. Levels of Care refer to services provided by the facility to the resident. Facility staff must have the ability to provide such services. Levels of Care are differentiated by the amount of assistance the resident requires.

NOTE: Do not report a Level of Care that has been applied for, but not approved by the end of the Calendar Year of the survey year.

Question 29

Level of Care 3+ Waivers:

The Level of Care 3+ waiver means that the patient requires a higher level of care than the facility is currently licensed to provide. If the facility can provide this level of care without harm to that patient or other patients, they apply to OHCQ to be granted authority to provide the higher level of care. Report only Level 3+ waivers if this has been approved by OHCQ.

Question 30

Alzheimer's Disease and Related Dementia:

The Facility may provide care to residents with various stages of Alzheimer's disease and/or related dementia. This must be in a organized program care. Residents referred to in this question should be those formally diagnosed by a licensed physician.

Question 31

Resident Characteristics-Assisted Living:

Summary demographic data of the facility’s census as of the Ending Date of Operation for the following: Gender, Age, and Race. The total of each demographic group must be the same as the number of residents reported on the last day of the year.

Question 32

Continence – Assisted Living:

Summary demographic data on the bowel and bladder continence of residents on the facility's census on the Ending Date of Operation. The total of each demographic group must be the same as the number of residents reported on the last day of the year.

Continent - Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.)

Usually Continent - Bladder incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.

Occasionally Incontinent - Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.

Frequently Incontinent - Bladder incontinent episodes tend to occur daily, but some control is present (e.g., on day shift); Bowel incontinent episodes occur two to three times per week.

Incontinent - Having little of no control (including inability to control care that involves prompted voiding, habit training, reminders, etc.)

Question 33

Cognition – Assisted Living:

Summary demographic data on the levels of patient mental functioning on the facility's census as of the Ending Date of Operation. The total of each demographic group must be the same as the number of residents reported on the last day of the year.

Independent - Resident's decisions were consistent and reasonable (reflecting lifestyle, culture, values); resident organized daily routine and made decisions in a consistent, reasonable, and organized fashion.

Modified Independence - Resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

Moderately Impaired - Resident's decisions were poor; resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

Severely Impaired - Resident's decision- making was severely impaired; resident never (or rarely) made decisions.

Question 34

Sources of Admission- Assisted Living:

Summary demographic data on the physical location of the residents at the time of their admission on the facility's census as of the Ending Date of Operation. The total of this demographic group must be the same as the number of residents admitted during the survey year.

Question 35

Sources of Discharge – Assisted Living:

Summary demographic data on the discharge destination of residents who left the facility during the Calendar Year. The total of this demographic group must be the same as the number of discharged residents reported during the year.

Question 36

Resident Distribution Data-- Chronic:

Summary demographic data of the facility's census as of the Ending Date of Operation for the following: Gender, Age, and Race. The total of each demographic group must be the same as the number of discharged residents reported during the year.

Question 37

County of Residence- Chronic:

Summary demographic data of the facility's census as of the Ending Date of Operation by county of Residence. The total of this demographic group must be the same as the number of discharged residents reported during the year.

Source of Admission- Chronic:

Summary demographic data of the facility's census as of the Ending Date of Operation by Source of Admission. The total of this demographic group must be the same as the number of discharged residents reported during the year

Primary Payment Source-Chronic:

Summary demographic data of the facility's census as of the Ending Date of Operation by Primary Payment Source. The total of this demographic group must be the same as the number of discharged residents reported during the year.

Question 38

Primary Diagnosis on Admission-Chronic:

Summary demographic data of the facility's census as of the Ending Date of Operation by Primary Payment Source on Admission. The total of this demographic group must be the same as the number of discharged residents reported during the year.

Question 39

Discharged Destination-Chronic:

Summary demographic data on the discharge destination of residents who left the facility during the Calendar Year. The total of this demographic group must be the same as the number of discharged residents reported during the year.

Question 40:

Direct Payment CCRC:

Additional clarification and definitions can be found under Regulation COMAR 10.24.01.01B .

Section 4—RATES AND CHARGES

Question 41

Private Pay Charges:

The range of daily base room and board rates for private pay residents as of the Ending Date of Operation. The rates reported should reflect the basic minimum and maximum rates, including room and board and routine nursing care. Ancillary services should be excluded from the base room and board rates.

Question 42

Government Payer Rates:

The range of daily base room and board rates paid by government payers for veterans Administration and Medicare residents as of the Ending Date of Operation. The rates reported for minimum and maximum should be all inclusive.

Adult Day Care Centers: Report only your undiscounted daily rates.

Section 4--SERVICES

Question 43

Secure Alzheimer's Unit:

Unit or licensed beds reserved at the facility specifically for the treatment of Alzheimer's care residents. This does not include a resident that was admitted with Alzheimer's and was placed in a licensed comprehensive care, assisted living or chronic bed. The unit and beds have to be dedicated for that purpose only.

24-Hour Awake Staff:

The facility is open and operating 24-hours per day and has awake staff assigned for every hour.

Services Available:

The types of medical and other services available to residents at the facility.

Question 44

Services Provided—Adult Day Care:

Services provided to participants on-site and/or off-site by center staff, or through a contractual arrangement, during the year. Services may be provided On Site by the center or by a contracted 3rd Party or may be provided Off Site by the facility, or by a contracted 3rd Party.

Section 6—FINANCIAL INFORMATION

Question 45

Fiscal Year Reporting Period:

The Beginning and Ending Dates (BFY and EFY) of the Fiscal Year used by the Business Office for financial reporting.

Note: Comprehensive Care facilities - The Beginning and Ending Dates of Operation of the Fiscal Year should be the same dates used when preparing the MEDICAID Cost Report for the Fiscal year.

Note: The Fiscal Year must be 12 months if the facility operated for the full year, or less than 12 months if the facility opened or closed in the survey year. The Fiscal Year ending date must end in the same year as the survey year.

Question 46

Total Operating Expenses:

The total operating expenses incurred by the facility during the fiscal year. This is not total revenue.

NOTE 1: Only report the expenses for the facility type you are completing. If the facility has two (2) separate licenses, one to provide Comprehensive Care and one to provide Assisted Living, the facility will complete two separate surveys. Only the expenses for the appropriate bed license type should be reported in each survey.

Question 47

Number of Licensed Beds or Slots by Fiscal Year:

The total number of licensed beds at the Beginning and Ending Dates of the fiscal year reporting period. If the facility's Fiscal Period is the same as the Calendar Year, then the fiscal reporting dates reported would be as such; 01/01/20YY to 12/31/20YY.

Question 48:

Comprehensive Care Revenue Report:

A detailed report of financial information reporting the routine and special service revenues, and the number of patient days. This also includes allowances and adjustments to revenues. The Commission will use The MEDICAID cost report Schedules B and C and Page 3-Occupancy and Rate Data, to include the data for this question if your facility filed a MEDICAID cost report.

Maryland Medical Assistance Program Patient Days:

The total number of patient days provided under the Maryland Medical Assistance Program (MEDICAID) by each degree of care during the calendar year. This question is linked to the MEDICAID cost report routine days.

Bed Hold Days:

The total number of days a bed was held for a resident while the resident was temporarily out of the facility during the calendar year by revenue source. Include residents who were in an acute care hospital while a bed was being held at the facility.

NOTE 1: Medicaid personal days should be included in bed hold days.

NOTE 2: For the purpose of the Maryland Long Term Care Survey, a bed hold is defined as retaining a bed for 14 days or less for a resident.

Question 49

Chronic Care Revenue Report:

A detailed report of financial information reporting the routine and other revenues, and the number of patient days. This also includes allowances and adjustments to revenues.

NOTE 1: This question is asking for the total revenue for the whole facility. This is not a per bed or per day revenue amount.

Question 50

Assisted Living Revenue Report:

A detailed report of financial information reporting the routine and other revenues, and the number of patient days. This also includes allowances and adjustments to revenues.

NOTE 1: This question is asking for the total revenue for the whole facility. This is not a per bed or per day revenue amount.

Question 51

Adult Day Care Revenue Report:

A report of the center’s fiscal year revenue and participant days.

NOTE 1: The revenue reported for this question should be taken from the center’s financial report for the fiscal year that ended during the survey year. Report the total revenue for the whole center, not on a per bed or per day basis.

NOTE 2: The "Participant Days" is the cumulative total number of days of all participants' attendance during the fiscal year. A day of attendance is considered to be a minimum of four (4) hours of care at the center. Report participant days by revenue type. The total participant days should not exceed the total of all four (4) quarters for "Participants Present”.